N73-17061

Sensitivity to Emotional Ill Health in Employed Groups*

by

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> "Subtle, pervasive, and disruptive are useful adjectives to describe the characteristics of a majority of emotional problem cases in industry; subtle because the behavior of the individual is often not blatantly abnormal; pervasive because it can involve a unit or section for a considerable period of time before being properly identified; and disruptive because it so often distorts interpersonal relationships, and such relationships are at the core of effective functioning of a unit."
>
> Robert B. O'Connor, M.D.[1]

Preceptive in the operation of a social institution is effective functioning. The need for the maximum in human performance is all the more mandatory when the activity involves the use of public moneys, and the managers of those funds are remote designates of the tax-paying electorate. Particular emphasis on skill and efficiency is required when the supporting public has only a dramatic end result to judge by, and is unaware, usually, of the main minor successes which have given possibility to the major accomplishment.

There is further significance to effectiveness when the work processes are creativity and abstract thought rather than the unimaginative produc-

*Presented at the Annual Meeting, NASA Occupational Medicine and Environmental Health, New Orleans, Louisiana, October 23, 1969.

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tion of millions of marketable units utilizable by the individual homemaker. Art, research, literature, and dramatic performance, although subject to knowing professional, critical review, frequently are believed to be easily reached products that "anybody could do." Hence, the sharper the barbs which are levelled at the initiator, the planner, the designer, the thinker, or the theorist, by the person who sees only the slow process of creativity, yet expects the hustle, noise, and momentum of, say, a can factory. Responding both to a demanding public, or its selected officials, and an exacting management, the space worker has high expectations placed upon him. Meeting these expectations may be accomplished only through tremendous drains on his emotional economy.

Contemporary Mental Health Programming

In a discussion of emotional health with responsible and thoughtful occupational and environmental health directors from a large governmental agency, it seems only logical that the experience and views of this disciplinary body serve as the platform for a conceptual interchange. About two months ago a letter containing 10 questions (see appendix A) was sent to 50 persons listed as "key medical and environmental health personnel" in NASA headquarters and its primary installations. Replies were received, either detailed or cursory, from 11 physicians, six environmental health directors, and four lay medical managers, a total of 21 responses.* In five instances the environmental health personnel deferred to medical opinion at their sites, and 1 disclaimed all knowledge of this area of inquiry.

Of those not replying, there were nine physicians and 18 environmentalists, a total of 27, or 54 per cent of the group originally solicited.

* This number included opinions from two persons to whom the questionnaires were not sent, but who were in positions permitting opinions of worth.

Two of the reactions to the questionnaire were received in the form of telephone communications.

The information returned coursed from great awareness of emotionally generated problems at operational sites to complete disclaiming of the existence of such difficulties among workers. The environmentalists -- including industrial hygienists, health physicists, safety directors, and environmental health engineers -- ranged similarly from great sensitivity to work behavior to, presumably, a lack of knowledge or disinterest. Many of the replies were highly insightful and provided substantiation for a presentation in this particular occupational health area.

Specifics From the Field

Although the speculation can be broad regarding the nature of certain responses from certain individuals at certain installations, only some of the highlights will be offered.

Formal Program of Identification

No formal effort exists to identify behavioral problems among local personnel. The primary source of recognition lies, at one installation, in the product of a detailed automated medical history coupled with the Minnesota Multiphasic Personality Inventory (MMPI). The respondent reported that in many cases the responses to the two documents, when reviewed with the physical examinee, led him to discuss family and work problems which might not have been flushed out in the usual seeking of the medical history. At other sites, leads are obtained during pre-placement or periodic medical examinations, or during visits of employees to the health service. Several of those replying stated that supervisors and security officials will serve as informal sources of referral of workers in need. At one research center, as part of a training program for supervisors, copies of the Civil Service Commission publication, Recognizing and Super-

viding Troubled Employees, are distributed. No evaluation of this procedure was mentioned.

Use of Mental Health Specialists

Nearly all medical services refer troubled employees to specialists extramural to the base. Primarily, psychiatrists are used, and when the health program is based in a large adjacent private clinic facility, staff members in psychiatry or psychology see workers on referral. No mental health specialists visit the local health services.

Sensitivity to Problems

Most of the physicians responding felt that their medical staffs were sensitive to personality change or problems, and several accredited to their nurses keenness in this kind of awareness. There was a feeling that nothing was done unless a behavioral question at issue became truly acute and then referral would be effected. Lacking was a sense of early intervention when help could be offered prior to irreversibility of the personality aberration. Few of the medical or paramedical personnel had had special training in occupational mental health.

Predominance of Problems in Specific Group

Because of experience many years ago with workers in the atomic energy industry, I have been curious as to the personal needs, or deficits, as manifested by behavioral differentials among various groups of craftsmen, scientists, engineers, managers, or other occupational incumbents. There has been concern over the move into administrative posts of engineering and computer science personnel because of their concern with "things" and problem-solving rather than a concern with, or an appreciation for, the delicacies and intricacies of interpersonal relations. The respondents

were divided on this point, probably in proportion to their interest. One felt that rotating shift workers had a great number of personal dificulties, usually at home, or with alcoholism. Another specified personnel at lower grades for they lacked understanding in the use of community resources. At one installation, technical and mechanical workers, professional engineers, and managerial personnel were placed in this order of frequency in demonstrating personal problems.

One respondent verbalized his selection as follows: "In general, the research scientists pose the greatest potential problem. Some live in a private world of their research and are completely oblivious of what goes on around them." From another observer came this paralleling statement: "At _____ there is a definite increase in emotional problems among the scientists working on research projects. They are...trying to plan environmental studies and programs for flights anticipated in the late 1980's. They are working with many imponderables and unknowns and feel very insecure when their work is not showing the productivity that they feel their supervisor is demanding. This coupled with the fact that NASA is new and there has been constant reorganization of the various scientific departments here...would result in insecurity."

At one large facility, administrators were considered as the group in greatest need of personal problem resolution. Several of the respondents felt there was equity among all worker segments, and at one installation a study is being conducted to measure this point of group difference.

One writer made the interesting statement that, "Our employees are typically mature individuals having an average age of 47.4 and an average of 19½ years of Federal Service. In this small organization working with mature professional individuals, we have not felt the need to establish

any formal mental health program." It is of interest to read that being a quadragenarian implies "typical" maturity or that two decades of Federal employment will bestow a comparable freedom from emotional disruptions.

Examples of Impaired Functioning

The cases cited were of extreme interest and underscore the fact that whenever people are at work and endeavor to meet the daily environmental challenges, imbalances between personal strengths and external stresses will result. The illustrations are paraphrased.

Example No. 1

An electronics technician had recurrent "manic episodes" which required several hospitalizations. Rehabilitative trials through the team effort of the private psychiatrist, the health service physician, and the supervisor had been partially successful only. Although there had been long remissions related to lithium therapy, the employee has required tremendous expenditure of time and energy by Management and health service personnel.

Example No. 2

A 55-year-old, working in procurement, was extremely conscientious, competent, and efficient. He was of Irish lineage, and a younger man of Italian ancestry who worked for him was promoted over him as his immediate chief, possibly because the younger worker was much more aggressive. The 55-year-old became severely depressed, developed insomnia, was emotionally unstable and totally frustrated in being unable to find a position to which he could transfer, in his field and at the same GS level in the

large metropolitan area where he worked. The condition was not improved by a two-week vacation, and currently he is receiving psychiatric counsel. Up to the point of the change, his work has been outstanding, and he had recently received a merit promotion.

Example No. 3

A senior and highly qualified employee, divorced and living alone, became an alcoholic because of his continuing difficulty in meeting the legitimate demands of his supervisor. He could not measure up to the standards required and would avoid meeting the supervisor or performing the work by taking sick- or annual-leave and by over-indulging in alcohol consumption.

Example No. 4

A 46-year-old employee developed symptoms of extreme anxiety, had repeated periods of absence, and demonstrated fractious behavior, even toward the medical personnel. On investigation it was learned that the man's complaints about his supervisor were not unjustified. It could be documented that the supervisor had indeed put abnormal pressure on this worker to the point that he was using every mechanism available to him to avoid being at work and to avoid staying at his work station while at the facility. A transfer to another area and to another supervisor completely resolved this immediate problem.

Example No. 5

According to the employee who had been having difficulty with fellow workers, they had "picked on" him. He stated that the other men were trying to have their supervisor replaced

and that he had refused to take part in it. One night, armed with a loaded gun, he went to the homes of two of his fellow workers. He found one at home, and told him he would have shot them both if they had both been there. The one who was at home finally talked the patient into giving up the gun. He removed the bullets and the next day at work returned the gun to the patient. Three days later, the patient called another co-worker who was at home ill, and told him he (the patient) would have to get rid of six more people "before things would go right out there." A warrant was obtained, and the patient was picked up as he was leaving work, was detained in a psychiatric ward for two days, and was released under the care of his own psychiatrist. Subsequently he underwent disability retirement.

Example No. 6

In a particularly difficult situation, a research engineer believed that his investigative work had been "stolen" by some of his peers and supervisors. Counseling and medical care failed to rid the employee of this deeply ingrained belief. In the absence of a frankly diagnosed psychosis it was necessary finally to take disciplinary action. The entire case involved many hours of time of personnel including that of the Assistant Director.

Example No. 7

Most outstanding among the specific cases cited was one which involved a group of 150 craft workers highly skilled in meeting the exacting requirements of the engineers. Under a change in unit heads, the men became thoroughly demoralized.

There developed universal unhappiness, for what had been an elite group was now not unlike the workers of a production shop, where no longer was there the sense of one-of-a-kind production.

A planning group had been interposed between the craftsmen and the engineers so that the value and worth of the former close assocation now were gone. The employees had difficulty in articulating clearly their complaints, but when pressed to do so, stated that they were "treated like machines," having developed a sense of worthlessness, both personally and occupationally. They were trapped by long periods of service, not willing to forego long-structured pension privileges. Most of them could tell to a day, the time remaining until retirement.

Reorganization had been effected through the issuance of memoranda, without a personal orientation or clarification as to the changes, and without the opportunity for the men to respond. An interesting side light was that the workers had, in many instances, brought their own tools to the shop; now, they had taken these home, and were using those issued in the facility. Many of the men sought tranquilizers from the medical unit in order to continue their jobs, and one employee has been seeing a psychologist weekly, solely to release the anger generated by the work situation.

When the problem was presented to management, both the Director and Personnel Director felt restrained by Civil Service Regulations in being able to cope with it -- and the big blow goes on.

Relationship of Behavior to Performance in Observance of Precautions

Significant responses came from some who were working in environmental health. In one center, instances have been noted where, for no apparent reason, workers have refused to use personal protective devices. Some of these actions were believed traceable to abnormalities in personality of the employees involved. One instance had been recorded where an individual had purposely exposed himself to a specific material, developing a dermatitis in hopes of being transferred to another job. In some jobs carrying the so-called "he-man" image, such as steel-workers, workers have been observed refusing to wear safety devices for they felt that their use carried with it a "sissy" connotation. Another abnormal action consisted of the intentional exposure of film badge dosimeters by radiation workers to high levels of ionizing radiation.

The antithesis of this was encountered in a young scientist from abroad who became totally inefficient because of his fear of ionizing radiation. In spite of measurements by health-physicists and reassurance that there was no hazard, the man believed, as a scientist, that the established criteria were not sufficiently protective, and that his life was still in danger. Eventually he had to be discharged.

Occupational Mental Health Programs

In the main, no programs in this area have been launched. At one installation "a modest program" has been followed, consisting of detection through employee-patient visits and referrals from supervisors; rehabilitation on return to work through the team approach; follow-up on specific problems; consultation for employees with emergency status; training of supervisors in mental health; and investigation into work activities suspected of causing or triggering abnormal behavior patterns.

The only other effort reported came from a medical care source where there was a joint concern in alcoholism exercised with a local Alcoholics Anonymous group made up of several of the scientists who offered aid in caring for the problem when it arose.

Assistance Valued in Program Creation

Six of the respondents stated specifically that they would welcome assistance from mental health professionals in establishing a program, but that such an effort should be built into the on-going medical activity. There was one "maybe," and one person said "no." There was a comment in this connection redolent of days long past: "People are afraid of the words 'Mental Health.' They still associate 'Mental Health' with insanity." Worded specifically, one respondent stated that, "Any assistance leading to prevention of interpersonal conflict or emotional problems which can be effectively utilized would be welcome." At one installation, the medical director felt "the main effort now should be directed toward selling Management on the need for a comprehensive mental health program."

Sensitivity Training

Two of the persons queried replied that sessions of this kind had been conducted, and one mentioned a three-hour seminar on mental health which was included in supervisor training, as was a special series of "executive training sessions," of one week's duration, on a live-in basis. Such group efforts "were not encouraged" at one site, and at another where the group format had been used, "the response...was as varied as the personalities of those employees who took part in them." One comment was comparable to some of the remarks regarding civil rights -- "Sometime

in the future we may, but for now, we will have to wait and see."

Comparative Prevalence of Problems

In the main the consensus was that NASA workers, in comparison with groups in other industries, did not present any more problems than others. Some felt that this related to the careful selection of government employees.

Indications of Need

Nearly all evidence proferred by stressed employees can be subsumed under the designation of symptomatic behavior. The actions manifested by workers bespeak underlying turmoil even though the casual view of these persons may be unrevealing of any change in homeostasis.

Partial Withdrawal from Work

Even though a distaste for work has become a commonly bantered folk expression among Americans, work is a personally meaningful activity. Yet, when an individual is placed in an assignment anathema to his wishes, antithetical to his particular sensitivities, or polar to his particular value system, he is going to avoid, consciously or unconsciously, continuing contact with the stressor. He will escape for whatever brief time he can.

Chronic or repeated tardiness relates personal difficulties at home, or a disinclination to perform for a full day of work. Excessive duration of coffee breaks or similar work stoppages exercised over the allowed number, or constantly lengthened lunch hours permit the employee to shrink his actual work contact period. By absenting himself from the job, he elongates the separation from the unpleasant work scene. Inquiry regarding cause of the absence will evoke, usually, a wide variety of rather tired explanations relating to alleged personal illness, transportation breakdowns, or family crises in need of resolution. A supervisor need not be astonished by some of the bizarre rationalizations offered by employees highly experienced in this activity, and skilled in verbalizing with the straightest of faces.

Equally divisive of the employee from the work scene is a self-imposed task underload. This is seen in the individual who cannot produce the totality of what is expected within the normal time span. Again, there are always articulated excuses for not meeting deadlines or full production quotas or even top quality if it means an unusual effort.

Each of these behavior patterns depicts a disaffected person who will not meet work expectations for reasons to be determined by professional workers adept at teasing out the true causation from among the many superficially expressed and unsubstantial etiologies.

Total Flight

The syndrome of partial withdrawal can be extended to its fullest in the form of total flight from the site of stress. The worker manifests this by requesting frequent transfers from one job to another, or from one department to another. The stay in each may be of short duration, ending frequently in poor performance, supervisory dissatisfaction, or fractured interpersonal relations of the employee with his peers.

Turnover tells a tale of tension, either on the part of a single worker, or of a group. The job-hopper, the individual who has worked for many companies in a short period of time, is to be suspected of an emotional difficulty, for most persons in the labor force can demonstrate infrequent job changes. The solid, concerned employee learns new ground rules, establishes an appropriate set of work standards and adjusts to the needs of the position just obtained. Exploration of the basis for unduly frequent moves will elicit plausible explanations, but on finite dissection, there will be always uncovered certain situations or persons who will be blamed or viewed as the reasons for the individual's removing himself from the particular group or situation.

In studying the persons undergoing personal flight, it is always helpful to know if many have left a single unit, for often this is the only indication of stressful supervision. Like several of the examples cited previously, a foreman or leader common to a group of leavers might be identified as the problem universal to the resignees.

Partial Self-Destruction

For whatever unconscious reason might exist, a worker may attempt to destroy himself in part, because of what he perceives to be an intolerable situation. At one end of the spectrum is seen the person who undergoes work-overloading, and takes on many more assignments than he can either complete in a given time span or carry out with quality performance. Frequently this is done because of a long enduring habit of establishing standards for personal accomplishment which exceed reality.

A variant of the theme of self-destruction encountered in a more overt manner is seen with the employee given to "telling him off," when the "him" usually is his supervisor. This effort at "pointing out the truth," or "setting him straight," or not letting "him do this to me," usually leads to disciplinary action taken because of insubordination. The self-inflicted punishment may take the form of a reprimand, suspension, or discharge, any one of which partially destroys the employee when either his future with the company or his career is considered.

More dramatic forms of this behavior pattern are seen in "accidental" injury, particularly in employees who constantly re-injure themselves in a variety of work settings and with the involvement of diverse tools or equipment or vehicles.

Chronic alcoholism and drug abuse have serious consequences in employment, and are not only physiologically but vocationally destructive.

Total Self-Destruction

Lastly, there have been many depressed workers who have attempted suicide in more conscious fashion than through a job-related injury. Many times these attempts take place at the worksite or shortly after leaving. In a great number of instances, there is no explanation for the action and, on review, no tell-tale clues were recalled or found.

A most memorable suicide taking place in the health service of a government agency was the one reported, in essence, as follows:

> A white collar worker came to the dispensary stating that he was feeling ill and wished to lie down for a while. The Occupational Health Nurse gave him some medication and led him to a bed in the rest ward facility. Within a few minutes after she returned to her desk, she heard a gunshot from the rest area and on returning quickly found that the man had committed suicide.

Although more prolonged in the process of self-elimination, the two polar actions of excessive weight gain and excessive weight loss may be included. Many applicants for employment who demonstrate obesity may undertake crash dieting in order to meet a physical standard. Shortly after beginning the new position, the weight will return to its initial level.

The long-known entity of anorexia nervosa is seen infrequently but the destructive process is inherent in a self-enforced drop in weight either through the cessation of eating, or the ingestion of extremely low-calorie, high-bulk foods. At the moment of writing, an employee with this condition, in one of our departments, has gained a few pounds during the initial months of a work probation period in order to meet the weight criterion. It will be interesting to see if, when tenure of employment is obtained, the weight will remain at its new height or will drop to its morbid average.

Signs of Stress

Workers plagued by personal concerns almost flaunt the tell-tale signs of stress, for, in a sense, they are seeking help which they are unable to ask for in the more usual format of requesting assistance. The sensitive physician or paramedical specialist, with perceptive acumen, will identify the behavior patterns indicative of turmoil within.

An increase in the amount of dispensary visitation is a clue. The ostensible reasons might be major or minor illnesses or injuries; simple requests for information or merely conversation; the need for confirmation of a private physician's diagnosis or treatment plan; or the need for "just a couple of aspirins." The characteristic is not the nature of the visit to the medical department, but the frequency. There are the innumerable contacts with members of the professional team which ordinarily end in the staff member's providing what seems to be indicated. But a permanent meeting of the recidivist's needs will take place only when a wise physician or nurse or technician will suggest that the deep reason for the many visits be explored and identified. Sensitivity to the needs may be shown by a clerk or a receptionist who has a feel for what is really indicated by the many dispensary contacts.

Certain psychophysiologic responses are commonly seen as reactions to stress: tension headaches, gastric, or more frequently, duodenal ulceration, neurodermatitis, myocardial infarction, or cerebrovascular accidents. To be sure, the matter of organ selection is never clear. Why does one person -- or one family -- develop headaches as a reaction to pressure, while another consistently has his skin speak for the external impingement on his emotional economy. Even minor clinical conditions, aphthous stomatitis or herpes simplex, can have their origins

traced to a slowly accelerating stress. It need not be said that the patient-employee presenting any of these disorders must be studied multidisciplinarily, and not have the controlling clinical judgment exercised solely by a rigid somaticist.

Domestic Problems

Although many laymen believe with the most solid of convictions that work causes difficulties in emotional balance, persons in constant touch with employees see home problems which can be faulted as causative of ineffective job performance.* Family differences between parents and children, particularly those seen today when an irrational reaction to hair's length or skirt's brevity can lead to long-enduring alienation, are brought to the job and becloud or limit the peak expression of occupational skill. Working parents cannot shed the weight of their worries when they begin the workday, and the product, the service or the consultation turned out is lacklustre in quality.

The working mother will, as she always has, lead two lives, and the demands of family integration will lead to tardiness, absence, excessive telephoning, or shortened workdays because of baby sitter, nursery school, or transportation constraints. Even though all elements of the planned existence may go according to the most exacting of timetables, she still has family tasks on arriving home. It is a busy, a full, an emotionally split day she spends as an employee.

If the working mother happens to be a professional person, and if her husband has a comparable career, there may be rivalries between the two which could prove divisive rather than cohesive. (While speaking of sex differences in the working population, another strange item in status should be mentioned. A woman executive's secretary is of lower

*To be sure, work situations can, and do, lead to emotional disruptions, but usually when predisposing factors in the worker's life are rekindled by a stress which cannot be coped with by the person's usual life style of meeting pressure.

status than the one who works for a man, according to unofficial hierarchial values of secretaries, and this may lead to problems with the secretary or with the executive.)

As a final example of difficulties tangentially related to the domestic scene which encroach upon work, there is the problem of transportation to and from work. Temporary blocks to traffic on freeways and expressways, vehicle breakdowns, and the constraints of carpools may be reflected at both ends of the daily trip and not only relight short fuses but replace effectiveness by impaired performance.

Racial Difficulties

Lastly, there are the disturbing elements in human relations brought about through ethnic differences. Whereas at an earlier date a black person would not be hired because of his color, irrespective of his capability, today there is the reverse of the coin in the employment market. Many blacks are being sought for good positions, but the prospective worker wants to be sure that he is being employed for his capacities and not merely because of his color. Wisely, these persons do not want to be the token employee, or as a black psychiatrist friend of mine put it, "I don't want to be _____'s nigger boy."

Discrimination and prejudice are terms or feelings interpreted and misinterpreted as different viewers describe the scene. An incapable black accuses the employer of bigotry if another person is hired (black or white) who has greater efficiency in performance to offer an organization. If such an employee fails to work out well, it is because -- as perceived by the complainer -- the company, the employer, or the supervisor is prejudiced. The understanding that one must produce, irrespective of hue, is yet to pervade the thinking of vast numbers of

workers. Also to be rectified in the thinking of personnel is that the status of a position itself does not necessarily permit mediocrity or sloth, but is more demanding of quality work than were the status lower. It is hoped that the Peter principle will not enter into industry's efforts to place members of minority groups.

As workers are being recruited from poverty areas, one sees great pressures exerted on the new incumbents. There are, in essence, two cultural shocks experienced by the worker from the underprivileged area. First, he emerges from the ghetto to enter the community at large, which is an action in itself productive of apprehension. The second shock follows the move into the industrial society with all of its regulations, mores, behavior demands, jargon, and individual missions. To adjust to both sudden shifts is a formidable process, and some are unable to remain within the physical and emotional confines of a job's "territory." It is almost impossible for most supervisors to realize the dimensions of these changes and their patience is tried as each endeavors to adjust to the other's demands or lacks. One day, the requirements of formalized or structured work will be realized, and the tensions between supervisor and supervised will ease.

In our own department, we placed an 18-year-old from a poverty area. He was a 10th-grade dropout and on being assigned to the Radiology Section to assist in film processing and filing, appeared in full-length laboratory coat. Having donned the garment, he believed himself to be a professional person. The absence of reality thinking was further underscored when he was asked about his vocational aspirations. He stated that he wished to be an electrical engineer, his response completely unencumbered by any knowledge of the educational preparation required. His tenure was short for, in spite of encouraging guidance and lengthy tolerance of behavioral deficits, neither his presence nor his promptness could ever be assumed.

What Can Be Done?

Train Staff in Problem Recognition

Through training, the staff can be sensitized by a mental health specialist, brought in as a consultant, to the personal needs displayed by employees. He can interview individual employees or job applicants, or he can review case histories presented at staff conferences, pointing out the behavior manifested and its most likely etiology.

Group sessions can be held so that staff members' attitudes can be queried and explored. From these can come understanding of one's own behavior, and, secondarily, insight into the behavior patterns of others. Encounter groups of this type may be traumatizing to both fragile, poorly woven personalities and rigid and brittle individuals, and should be conducted only with the leadership of one trained in this learning format.

Most needed is the nurturing in the staff member of the curiosity to ask himself of a problem-beset employee, "Why did he do this?" or "Why did he say that?" or "Why does he relate badly to older men?" or "Why are his technical skills so superb and his social skills so immature?" There must be this intellectural questioning of behavior styles as part of learning. Further, with the understanding that will come from any of these self-growth mechanisms, there will be a replacement of the more primitive responses one might feel on interacting with a difficult worker -- anger, punitive action, dismissal, or hasty, dismissing referral.

One can be guided by performance evaluations prepared by the troubled employee's supervisor. These descriptions can bring into focus behavior characteristics which the patient has repressed, or does not wish to mention. The astute supervisor, while not always an interpreter, is usually an excellent observer, and his comments can serve as clues and guidelines in working with an employee. An example of one action

involved our own department. A supply clerk elsewhere altered a requisition so that our request for 5,000 tongue depressors, a four-months' supply, materialized into the delivery of 50,000 such items. When asked the reason for the change, the response was, "I wanted to teach X [our order clerk] a lesson." There was no basis or need for the "lesson."

There is a genuine roadblock in identifying persons at emotional risk, and this is attested to, with considerable feeling, by one of your own medical directors, when he wrote,

> "Some of the most formidable problems we face here [relate to] the directives of the Civil Service Commission in Washington [which] have made it literally impossible to legally delve into emotional or psychological profiles of any civil servant. This has proven to be a real handicap to all of us in many ways. In all candor, we find that the personnel divisions are... operating at their wits' ends in almost every instance of a problem involving a NASA employee who is having any behavioral problem of any sort. They are literally frightened to the point of inactivity in most instances for fear of being found vulnerable to attack by individuals oftentimes represented by their union who have been encouraged by the Civil Service directives resulting from our well-meaning members of Congress in this misguided efforts to properly protect an individual. They have, in fact, almost completely obviated any effort to[ward] a pragmatic approach which certainly has been a time-honored, well-established and effective program in many industries."

The essence of the complaint is that physicians working in federal installations may not use a printed medical history form which contains questions in sensitive areas. They are permitted, however, to ask these questions in conjunction with a physical examination and record significant answers. The form will be maintained in a separate, locked file.[2] Medical questionnaires are invaluable in eliciting pertinent behavioral data, and, in their development, it has been demonstrated that they bring to light more clues for diagnostic search than the history taken orally by the physician. One day, their use may return when medical policy is determined by persons in medicine and not by those in administrative or legislative areas.

Train Staff in Reassurance

Members of a medical department can be trained in listening. Implicit in listening are total attention; observation of all gestures, facial expressions, and positional or composure changes; hearing of alterations in manner of speaking; and the elimination of all disruptive interventions such as telephone calls, or the entry of other staff members. Listening means hearing not only the words spoken but the tone with which they are uttered, and correlating the words with hesitation in speech, with eversion of glance, with crying, or with anger.

Listening means, in addition, maintaining silence when the patient is silent, and avoiding interruption of an unfinished sentence either with words of tangential significance or by completion of the sentence.

Reassurance carries with it the provision of emotional support, and this can be effected in different ways as determined by the intelligence level of the employee, the nature of the worry, or the

duration of the problem. One usually speaks of the worker's being "upset," rather than "disturbed;" he has been subject to strain, or stress, rather than his having a "psychological problem." Stress, in all forms, is in common parlance today, and the word enters a number of disciplines. It may be considered fashionable to be stressed, but deprecating to be churned psychologically.

In reassuring a distraught person, one emphasizes the lack of uniqueness of the problem, and the knowledge that such a situation has been faced by innumerable others in the past. One points out that the problem will, in no sense, make medical history, reassuring the individual by emphasizing the commonality of the difficulty. So many troubled employees believe themselves the only ones who have become embroiled in their particular difficulties. Confirmation that hundreds have had similar difficulties is reassuring for it no longer makes them alone in society or different from other humans. Reassurance does not imply that the problem is viewed lightly or as insignificant by the listener; rather, when provided warmly, establishes contact with the troubled person so that he will accept the options in care.

Basic to reassurance is the clarification of need. The professional explains the need for counselling or therapy; that medicines are not indicated; that the physical symptoms are speaking for unsettled emotional requirements; and that care does not necessarily mean unending analysis or institutionalization. To be given emphasis, though, is the sense of immediacy in meeting the need for professional attention, and that procrastination will intensify, rather than resolve, the problem. Reassurance is always accompanied by the explanation that there <u>are</u> methods of resolution and that there <u>are</u> trained people skilled in working in these areas.

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Train Staff in Referral

Referrals made for such employees are not to be accomplished in a cursory fashion. An appropriate counsellor or therapist should be selected, and, if agreed upon by the patient, should be informed by telephone of the service requested, of the peculiar needs, and of the pertinent historical, behavioral details. This should be followed by a letter confirming the discussion. The person making the referral should request specific assistance if an administrative decision rests on the consultant's opinion. Should this person return to his present job assignment? Should he continue to work while initiating care? Should arrangements be made for long-term care (sick leave, authorized absence)? Should his job be enlarged, diminished, or remain the same? Is he in need of a different supervisor? What is the work-life prognosis? Only by placing these specific questions can one be given leads in guiding management when the employee's problem distinctly affects his work capacity or performance.

Referrals are not to be handled lightly on either side. The patient must be informed of the nature of the consultant -- that he is a psychiatrist, a psychologist, a counsellor, or a behavior-oriented internist. Further, the patient should reach an understanding at the time of the first visit of the professional fees and his financial obligations. If these cannot be met, then further assistance is required in seeking other referral sources where the costs are less or there are no charges.

Staffing

The addition of a mental health specialist to the medical department staff will bring unequalled in-service educational opportunities.

As a base for teaching, there are certain employees whom he might see on referral from the physicians, nurses, and environmentalists. Case reviews, as indicated previously, are invaluable instructional aids, and create ports of entry for the psychologist or psychiatrist or psychiatric social worker to consult with supervisors and members of mangement. The addition of such a person was suggested in a study conducted at NASA headquarters several months ago, but nothing has materialized from the fine review carried on of personal needs at that site.

Most rewarding is the clarification of worker behavior patterns, so that the employee presenting any of the syndromes indicated before can be viewed in the new light of understanding and helped affirmatively and with confidence.

The Medical Director has an important role in a program of mental health. He can orient members of management to the entire subject of behavior, supervisor identification of problems, referral, and probably, most importantly, to the essential qualities of patience and tolerance, new to many mission-consumed top administrators. Further, he can orient new employees to the diagnostic and therapeutic methods utilized in a behavior-conscious medical facility. This will prepare future patients for the kinds of queries and type of individual concern to be found when reporting to the health service at time of need. To be averted is the frequent rejoinder encountered which, in paraphrase, goes, "All I wanted was some aspirin and they psychoanalyzed me."

The Role of the Environmentalist

In the responses received from the environmental health personnel, there were few comments regarding worker behavior. In the motion picture film developed and shown here, descriptive of industrial hygiene activities, the environment was considered strictly as a physical-chemical-biologic complex, with no behavioral aspects or content.

Physicians with considerable occupational health experience can recall many examples of workers with job-related illnesses whose disorders were accelerated or accentuated by emotional factors. It is just these ancillary items in etiology that the environmentalist should seek out in identifying the cause of untoward physiologic responses. He, like other staff members, can be aware of psychosocial deficits detectable in the acquisition of occupational illness and in the failure to use personal protective devices or to follow precautions advised for hazardous operations.

To do a complete job in protecting the employee against the impinging environment, the environmentalist must be sensitive to sociologic and psychologic pressures, and interweave their effects into those resulting from the more physical challenges to the organism.

That there is resistance to the acquisition of such additional material to the working kit of the environmentalist was given testimony a few months ago when a paper was presented to a meeting of industrial hygienists on the significance of mental health to his relationships with employees and to the successful completion of his professional responsibilities. Approximately one-quarter of the audience left at the completion of the paper just preceding. Is the environmentalist apprehensive about learning in this area? Is it, as he perceives it, completely foreign and unrelated to his functions? Or, does he truly believe that what he does at the industrial scene is something totally apart from the human beings he is involved with

in an instrumental sense? As more voice is currently being given the environment by government, laymen, and ecologists and planners, the industrial hygienist, the health physicist, and the engineer will learn that each is intimately involved with the behavior of man in his roles of despoiler, worker, and community citizen.

What Are the Roadblocks?

What is the basis for the slow pacing of mental health programs at the worksite? Apart from ignorance, fear, or "weakness," in the employee which makes him reluctant to share his concerns, are the medical personnel apprehensive that, in the process of program activation and execution, there will be a disclosure of their own psychic problems? Do they believe that it is too late to acquire this additional body of knowledge?

Is one-to-one personal confrontation an uncomfortable or disturbing experience for those unused to psychodiagnosis and counselling? Do they believe that there is no time for this kind of program in a full day of examination, treatment, and consultation? Whatever the reason offered, successful mental health activities have been born and nurtured to productive maturity once there is realization that one's job satisfaction can be increased by this supplement of understanding.

Essence of the Effort

The only method to be used in initiating this element of an occupational health undertaking is to act supportively, and to be warm, welcoming, and compassionate with employees in need. From this attitude can grow the deep concern with the mental health of those whose health, effectiveness, and happiness it is your rare privilege to hold in stewardship.

APPENDIX A

Questions presented by mail to NASA key medical and environmental health personnel:

1. Is there any formal effort to identify problems of behavior or emotional ill health among NASA personnel at your installation?
2. Do any of you utilize the services of mental health professionals, such as psychologists, psychiatrists, or psychiatric social workers?
3. Are your physicians or environmental health personnel sensitive to changes in mood, thought, or behavior in employees?
4. Do you feel that one group of workers presents more problems in this area than others, e.g., engineers, administrators, flight personnel, maintenance workers, or any other group?
5. Can you recall a specific instance of impaired functioning because of personality difficulties? If so, could you provide a single paragraph abstract of such a case illustration?
6. To those of you in environmental health, do you believe there is any relationship of behavior to performance, as you have seen workers observe, or fail to observe, precautions in health hazardous areas?
7. Has any program ever been attempted in occupational mental health and failed? If so, why did this happen?

8. Would you value any specific assistance in establishing a program in this area, whether it is attempted as such, or is insinuated into the ongoing medical activity?

9. Have any sensitivity training, T sessions, or group discussions ever been held among supervisory personnel, even if these were conducted under the auspices of departments other than the medical facility?

10. With your knowledge of industrial establishments in manufacturing, research, government, or commerce, would you say that personnel at your installation present more problems than workers in these other undertakings?

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